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District Nursing

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Editorial

DURING the last eleven years more and more local authorities have been taking over the running of their district nursing services from the nursing associations. The trend continues, with Liverpool and London giving notice of their intention to administer their district nursing services from next year.

The one hundred and forty-five local health authorities in England and Wales had a choice in 1948 between administering the district nursing service themselves or making use of the existing county and district nursing associations. Seventy-nine elected to run the service direct and sixty-six to use the associations as their agents.

By the end of 1958 another thirty-one authorities were administering the service themselves. During this year a further eight authorities have assumed direct control, bringing the figures to one hundred and eighteen directly controlled services and twenty-seven run through agencies.

The local health authorities were faced with an immense task in implementing the National Health Service Act. The delegation for the time being, of district nursing administration to the existing voluntary associations which had long years of experience in running a first-class service, allowed the authorities to concentrate on other, more urgent aspects of the Act. The eleven years which have elapsed have in many cases given sufficient time for this and more authorities are now ready to assume control of a service for which they are responsible, and to integrate its administration with that of the other public health services.

The initiative has not always come from the local authority. Many voluntary associations have had to give up through lack of young people to replace committee members who have retired or died.

The transfer has always been accompanied by the closest co-operation between the two parties, in such harmony that the most important party, the citizen, has not been aware of any change.

For whatever the evolution in administration and organisation, the goal of all remains steadfast, to bring the best possible service they can to the sick in their own homes.

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The Community's aim is the dedication, under vows of religion, of those desiring to give themselves to the glory of God in ministering to the sick, and for the sanctification of the homes of those to whom they minister

Under Vows of Religion

by MADELINE, N.S.S.J.D.

THE Community of the Nursing Sisters of St. John the Divine was founded within the Church of England in 1848 by Robert Bentley Todd, Professor of Physiology, King's College, London. Its work started at 36 Fitzroy Square in July of that year.

Professor Todd's object was to provide nurses for the care of the sick, of a better type than those in existence in the early nineteenth century. He believed that this could only be done by a band of women living under religious discipline.

The Community has as its aim the dedication, under vows of religion, of those desiring to give themselves to the glory of God in ministering to the sick, and for the sanctification of the homes of those to whom they minister.

The Community originally trained their nurses at King's College Hospital, and later at St. John's Hospital, Lewisham, which the Sisterhood founded. Their midwives received training first at King's, and then from 1876 in St. John's Maternity home at Chelsea.

This article is concerned with one aspect only of our work, that of district nursing and district midwifery. Our other sphere of work is a nursing home at Hastings.

Work in the homes of the "sick poor" was started in 1852. The report for that year states "that in addition to regular attendance upon the sick poor, nurses are sent daily to the aged and infirm." It goes on to say that "the nurses have devoted themselves to this portion of the work with zeal and evident pleasure."

Records were kept, and a century-old example may be of interest:—

> "Jan. 8th 1852 . . . suffering with severe abscesses, attended twice daily, change of linen and sheets provided, also a dinner."

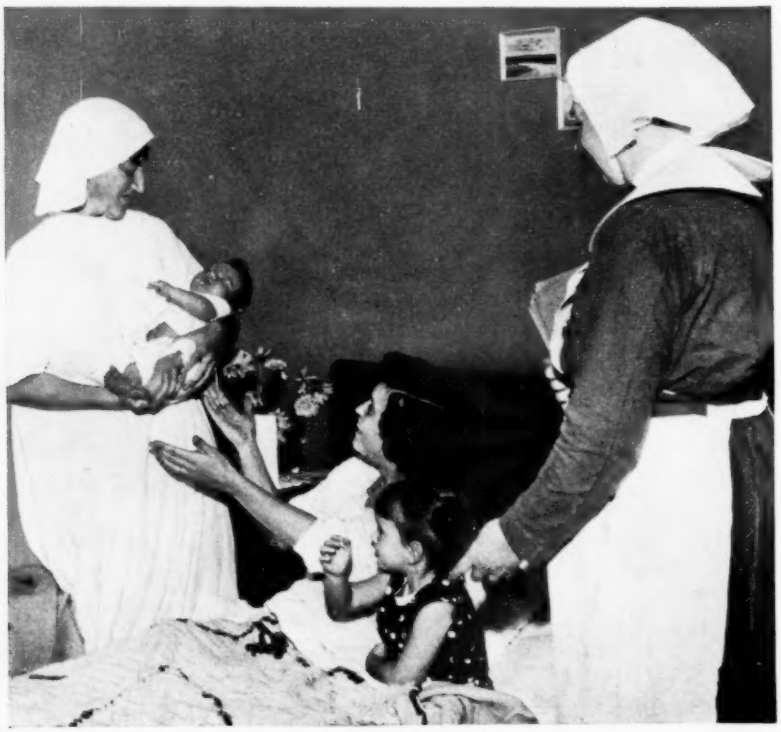
Most of the work of the Sisters was in London. In 1866 the East End of London suffered from a severe cholera epidemic which reached its height in the parish of St. Peter's, London Docks. The authorities applied to St. John's House for nursing sisters who were supplied.

Sometimes the call came from outside London. One such was from a large colliery district in Staffordshire where a virulent type of typhoid fever prevailed in epidemic form. Almost simultaneously sisters and nurses were called upon to deal with a fatal type of scarlet fever which had broken out at Mitcham and Cheddington and a village in Buckinghamshire where the vicar, a doctor and two nurses from St. John's House died. This caused so great a panic that it fell to the lot of the nurses to burn bedding, to wash the linen and even to place the dead in their coffins, for the undertakers would not touch the dead nor enter the houses.

In 1880 work was started in the East End at Poplar and soon afterwards in south-east London at Deptford. From the beginning both district nursing and district midwifery were undertaken.

In these two areas our district work has continued without interruption until the present time; the sisters themselves work on both districts and also employ nursing staff from outside the Community. Some of the sisters have received their district training from the Queen's Institute of District Nursing, others in conjunction with the Ranyard nurses, with whom for several years an arrangement has been made by which our districts may be used for training purposes.

On the midwifery side, our homes are recognised by the Central Midwives



The new member of the family is welcomed by mother and big sister

Board as a part II training school for pupil midwives. The pupils spend the whole six months on the district either at Deptford or at Poplar, so having time to gain confidence and experience. Last year we attended 500 midwifery patients on our districts, and we have our own ante-natal and post-natal clinics.

This is a very brief summary of our history and work. Our aim today is still the same as it was over 100 years ago, although conditions have changed so much—that of dedicating ourselves to the glory of God in ministering to the sick and suffering and the hallowing of home life.

Many years ago when the registration of nurses was first discussed the then Superior writing in her annual report said: "Long may it be before it is considered that professional skill and proficiency are *all* that is essential for success in the high calling of a nurse."

It is this vocational aspect of nursing that we, however imperfectly, still seek to foster.

One of the Sisters, helped by a nurse from outside the Community, prepares to give an injection in the general district surgery

CONVALESCENT TREATMENT

A New Approach

A MORE vigorous attack on the rehabilitation of the sick, similar to that developed in the rehabilitation of the disabled, and a new approach to convalescent treatment as a whole, are urged in the report of a working party on convalescent treatment. Greater interest in the subject at all levels and particularly by the medical profession, research into the problems of convalescence, and a larger study of the relative roles and comparative costs of recovery homes, rehabilitation units and convalescent hospitals and homes are required.

Although the working party limited its investigations to the area covered by the four Metropolitan regional hospital boards, the report is of more than local significance, and may well apply in varying degree to all parts of the country. It emphasises that "the hospital service should realise that (at least in the London area) it is not fulfilling its obligation to provide necessary convalescent treatment for many types of cases."

The report recommends that each Metropolitan regional hospital board should regrade convalescent facilities into homes where active treatment is given (to be known as convalescent hospitals), and homes which can give only the recuperative holiday type of care. The latter should no longer be the responsibility of the hospital service.

The convalescent hospitals retained should be upgraded where necessary, and close attention should be paid to problems of convalescence in general and particularly to the problems involved in the active rehabilitation of the sick.

A convalescent information bureau to secure better co-ordination in the exchange of information and advisement on placing is needed. Trials should be made of accommodation suitable for convalescence within or near hospitals, and with facilities such as physiotherapy provided by the parent hospital, the experimental provision of day convalescent centres based on the department of physical medicine at general hospitals in large centres of population, and the use of accommodation for convalescents for preventive and preparatory treatment.

The working party suggests further enquiry into facilities for convalescent treatment in other areas of England and Wales; special accommodation for the early stages of convalescence; and the present need and provision for recuperative holidays which local health authorities have power to provide.

"The treatment of convalescence has remained a medical and nursing backwater" states the report. "It needs to become more active, more planned and more integrated with other aspects and disciplines of medicine."

Nursing the Sick Child at Home—II

by VERONICA McCARTHY, S.R.N., S.C.M., Q.N. and H.V. certs.
Superintendent, Home Nursing Service, Rotherham

IT is a well known fact that a young child can become greatly upset when separated from its mother, and whilst in some cases separation is inevitable, in many instances sick children can be nursed at home. This reserves hospital cots and beds for more urgent cases and, even more important, cuts down the risk of cross-infection.

Therefore the ideal place for a sick child to be nursed, whenever possible, is at home with his parents. He has a feeling of security in familiar surroundings, with the presence of both parents; and there is no doubt that these play a very large part in the recovery of the child.

It is possible with the co-operation of the family doctor and parents, to treat the most poorly child in its own home with a minimum of upset and tears. For instance, the ever-increasing use of antibiotics has reduced the length and severity of many illnesses today, so that a child suffering from pneumonia who is very ill on a first visit, may show a marked improvement with signs of a rapid recovery within 14 to 48 hours. Under the provisions of the National Health Service Act the doctor may ask a consultant to visit the child at home for specialist advice if he thinks it necessary.

The main requirements for nursing a child at home are:

1. Co-operation of the parents.
2. The attendance of a trained district nurse who must be prepared to pay two or more visits daily for the first few days.
3. Whenever possible the child to be nursed in a room with an open fire, the room to be kept at the same temperature day and night. If a gas or electric fire has to be used, a bowl of water must be placed in front of it to prevent the atmosphere becoming hot and dry.
4. A well ventilated room, as fresh air is essential.
5. Fluids given often. This must be emphasised to parents, especially when caring for the very young child who is unable to ask for a drink.
6. Frequent warm sponging of the child who is perspiring, great care being taken not to uncover him too much. The nurse will teach the mother and instruct her to do this in her absence.
7. The child to be kept as quiet as possible, and visits from neighbours and other children discouraged.
8. The very ill baby must not be left at all during the night. It is advisable that the mother should stay up with the child. When she has to do so, she will need additional help during the day to prepare meals and help care for the rest of the family. Usually a two or three-year-old will not allow the mother out of his sight for the first day or two. If no relatives are available to help, the nurse can ask the home help service to assist.
9. Many mothers have a peculiar idea that a sick child should wear extra cardigans, etc. The nurse must tactfully but firmly remove these and explain how they restrict the child's breathing and also make him too hot and uncomfortable.

All treatment ordered by the doctor should be carried out and the mother shown how to measure and give medicine, and how to crush tablets and disguise these when necessary.

Antibiotics such as penicillin or streptomycin should be prepared in another room out of sight of the child. The mother or father can be asked to hold the child in position whilst the injection is being given. It is very helpful to have a feed or drink of glucose water or orange juice ready to give the child immediately afterwards. This helps to take his mind off the injection and to minimise the shock.

In some cases the very young baby suffers some degree of shock immediately after an injection has been given. He turns very pale, goes limp; he may not cry, but rather tends to hold his breath. This can be very startling not only for the nurse but also for the mother, and a warm drink given immediately after will do much to alleviate this. All such cases must be reported to the doctor. There is a possibility that the giving of injections may upset the baby and his parents to such an extent that the doctor may discontinue them. Nowadays the use of oral antibiotics has largely replaced injections.

Special Care with Infectious Cases

The nursing at home of a child suffering from an infectious illness calls for co-operation from the whole family. The patient should be isolated and instructions given to keep other children away from him. Special equipment is taken from the nurses' home for the nursing of all infectious cases, so the nurse need not take her nursing bag into the sick room.

The isolation tin contains: Two gowns and a supply of masks. Rubber gloves. Soap, nail-brush and towel. Receiver and small bowl. Methylated spirit. Pure Dettol. Dusting powder. Thermometer, thermometer lotion and swabs. Hypodermic syringe and needles. Scissors. Envelopes and message papers.

The extra gown is for the mother. She should be instructed to wear it while attending to the baby's toilet, when handling and washing soiled napkins and clothing

but *not* when preparing the baby's food. She should also be instructed on the importance of keeping all the baby's soiled clothes separate from those of the other children. The former should be put to soak in the sick room in a pail of five per cent Dettol and left twelve hours before washing. When possible they should be dried outside.

The baby should be handled as little as possible; most of his needs can be attended to in the cot. He should *not* be picked up every few minutes.

If the child is suffering from measles or whooping cough, a supply of small pieces of clean soft old linen should be kept handy to wipe his nose. These can be placed in a paper bag and burned after use.

Children suffering from pneumonia and bronchitis should be nursed well propped up. Great stress must be laid on the use of pillows, especially for young babies. Always place these under the mattress: this will raise the child's head and shoulders to enable him to breathe. If necessary a steam kettle can be rigged up and a clothes-horse covered with a flanellette blanket used to make the tent; or a vapour lamp may be used.

The nursing of sick children at home has been carried out very successfully in Rotherham for almost ten years. During this time I have observed the following:

1. It is essential to have the complete co-operation of the mother. If she has made up her mind that the baby would be better in hospital, she usually manages to get her way.
2. A final visit from the nurse at about 11 to 11.30 p.m. does a tremendous amount to relieve the parents of any anxiety they may have about the baby's condition. (This is usually only necessary for the first few days of the child's illness.)
3. In an endeavour to get a toddler (who often refuses to drink from a cup) to take extra fluids, give him a feeding bottle. I have tried this on many occasions and it always works. The mother can be reassured that he can easily be weaned off it again.
4. During the first week a sick child wants his mother to be always beside him, day and night, so it is essential that she should have a settee or single bed in the same room to allow her to have some sleep when the child sleeps.
5. She should also have some help in the house, so that she need not worry about housework and cooking. This applies especially where there are several small children to be looked after.

In conclusion I would point out that the numbers of sick children in Rotherham are very much lower now than in 1949. This is due to many families being moved out of overcrowded homes, and given new houses on the housing estates. In the early days most of the very ill children we nursed were living in cramped conditions, often in two rooms. We were called in several times during the winter months to the same families, to one child or another. Last winter, after these people had been given new homes, in many instances we were not called in at all.

DISTRICT NURSE TRAINING

The following letter was circulated on 13th November 1959 to training authorities by the General Secretary, Queen's Institute of District Nursing, 57 Lower Belgrave Street, London, S.W.1.

In view of the large number of enquiries which have been received, I write to confirm that the Institute has submitted to the Minister of Health for approval, a syllabus for the four three months course of district nurse training.

As soon as approval is received, full details will be circulated to all training authorities to enable the syllabus to be adopted according to local needs.

A similar letter has been sent to non-training authorities

Centenary Appeal passes £100,000

UP to the date of this issue the Centenary Appeal has reached a total of approximately £123,000. It includes £15,000 from the Nuffield Provincial Hospitals Trust, specifically allocated to the William Rathbone Staff College at Liverpool. This of course is a gross total including the value of all Deeds of Covenant received and money donated under kindred arrangements. A very great deal of this has come from the splendid efforts of the district nurses who are still collecting and sending in large sums every week.

It is difficult to give an accurate account of the amount collected in counties and county boroughs. As far as our knowledge at headquarters goes, Gloucestershire is now leading the county list with £4,500 followed by Norfolk £2,987 and Berkshire £2,501. Of the boroughs, St. Helens is well ahead with £4,244. We have had some generous donations from industry lately, including £1,000 from the R. A. Pilkington Charitable Trust, and £500 from Messrs. Pilkington Brothers, The Corporation and Members of Lloyd's, Lloyd's Brokers and several others.

The Robert Morley broadcast is still producing a little money and the total so far is rather more than £3,200. Of this nearly one-third was collected in Hove through the special efforts of Hove and Portslade D.N.A.; our thanks are due to Mrs. Gardam and Mr. Clark.

We hope to reach half the target figure of £250,000 by 1st February.

The appeal staff would be grateful if money collected could be sent in to the appeal account as early as possible. Unless this is done they cannot compile accurate statistics of what has been raised in the various areas. There is one other very important reason: at present the appeal is receiving over £100 interest each month on money already collected. If money is sent in as quickly as possible, either to headquarters or to Glyn, Mills & Co., it can be used to increase this monthly interest and bring us nearer to the target. Thus we can multiply the money you collect for the appeal.

We should like to take this opportunity of thanking all those who have helped to collect the large amount of money which has already been received. **T.A.**

The Liverpool City Police Juvenile Liaison Officers Scheme was established in an effort to reduce juvenile delinquency. By discovering the underlying reason for an offence, Officers can treat the cause rather than the effect, and so keep children out of further trouble

Children and the Police

Edited from information supplied by the Chief Constable of Liverpool

THE first and foremost responsibility of the police service is the prevention of crime, and the Juvenile Liaison Scheme is now recognised as a fundamental part of the police service dealing with this responsibility.

Children are not born bad, but it is a significant fact that the young are the most prone to drift into criminal habits. Older persons do not so easily become recidivists. Fortunately, young people are also the most responsive to proper methods of reform. For these reasons the best results are likely to be achieved by concentrating every effort on preventing child recidivism, and by devising new and better methods of reform and rehabilitation. Prevention costs far less than punishment.

If juvenile delinquency can be reduced by these means, there is good reason to hope that the returns for more serious crime among adults will in turn improve. Criminal records of adults arrested—particularly for breaking and entering—reveal in many cases previous convictions dating back to juvenile or adolescent years, and often these records are continuous. When a survey was made the figure was found to be as high as 70 per cent.

Before the Liverpool City Police Juvenile Liaison Officers Scheme was established, the figures for recidivism among juveniles in the city showed that over a period of years the number of those appearing before the court who had previous records averaged more than 40 per cent. This fact—and the ever-increasing number of juveniles passing through the Liverpool Juvenile Court—indicated that some new method of prevention was needed.

To find out what could be done a survey of the city was made in 1949 by the police. They found that a large number of children committing minor offences were not fully aware of their wrongdoing and lacked the supervision necessary to prevent its recurrence. Many of these offences consisted of the petty theft of goods or money from places such as stores, industrial undertakings, and even schools, in circumstances in which there was a reluctance to prosecute, especially on recovery of the property. Other children, unruly and out of hand, playing truant or frequenting undesirable places, were obviously in need of supervision.

With these two classes—the incipient and petty offender—it was felt that some success would be achieved if they could be made to realise, in time, the seriousness of their behaviour without the sanctions of the law being invoked. It was soon apparent that the success of this scheme would depend on the active co-operation of all concerned with child welfare. Accordingly, the system was explained to head teachers, ministers of religion, youth organisers, and other persons similarly concerned with the welfare of juveniles. They were, and have continued to be, most co-operative and enthusiastic. In a surprisingly short time the existence of the scheme became well-known throughout the city and its development proceeded rapidly.

The liaison officers are empowered to deal with children who are under 17 years of age, and on their own admission have committed a minor offence such as petty theft. (An offence of breaking and entering premises is not considered to be minor.) It is also a prior condition that such a child must never have come to the notice of the police before, and that their parents agree to accept any help and advice that may be given to them.

The majority of cases come to the juvenile liaison officer through normal police channels, that is the uniformed branch or criminal investigation department. In these cases the relevant officer may suggest that the child be dealt with by caution from the divisional superintendent followed by a period under the care of the juvenile liaison officer, but the decision is made in every case by the Assistant Chief Constable (Crime). When a case is approved the juvenile liaison officer makes his first contact with the child and his parents by warning them to attend the superintendent's office.

First Contact with the Child

If a case of shoplifting or petty crime is reported direct to the juvenile liaison officer he first satisfies himself that the child has not come to the notice of the police. He then interviews him in the presence of his parents, following which he makes a full report of the case suggesting that he be allowed to caution the child and look after him.

The juvenile liaison officer, on receiving a case, makes every effort to get at the root of the trouble and to find the underlying reason for the offence. Its seriousness is impressed on both the offender and on his parents and arrangements are made with the parents for a period of care and guidance, which varies according to the child and his home environment. Where necessary, advice is given to the parents as to the treatment of the child and, should the circumstances demand, other social organisations are called upon to assist the family. The head teacher, and any other person or body concerned with the welfare of the individual child, is then acquainted with the full facts of the case.

At the outset of the scheme the juvenile liaison officers were received with some reserve, but this soon disappeared

when it was explained that their mission was to help children to keep out of trouble rather than to prosecute them. Today there is a very close degree of co-operation between parents, teachers, probation officers, welfare organisations and the juvenile liaison officers. In fact a striking feature on the development of the scheme has been the increasing use made of it by head teachers, who call upon the liaison officer in difficult cases where they desire to influence unsatisfactory or indifferent parents to become alive to their responsibilities.

In November, 1957, it was decided to extend the work of the women police juvenile liaison officers to include moral welfare work among females under 17 years of age, who had been or were likely to become exposed to moral danger in one way or another.

Policewomen Help Young Girls

This extension has been amply justified, their efforts are having the most encouraging results and these policewomen are doing much to prevent young girls from falling into moral danger. During 1958 the number of girls dealt with totalled 707, of which 417 became visiting cases. Of the remainder 60 were missing from outside the city and returned home, 56 were referred to various social services, and 174 were given advice.

In every case referred to the department where the girl normally resides at home with her family, providing it is in the Liverpool area, the home is visited and the parents seen. For example, should a girl be reported missing from home, enquiries are made in an effort to trace her and once she is traced, she is restored to her home in most cases, or should the home be a bad one, alternative accommodation is found. The reason for her running away is thoroughly investigated by the officers, and everything possible done to right any bad feeling between the parents and the child. Subsequently regular visits to the home may be arranged with the consent of the parents, and a record of progress is maintained.

Girls missing from home represent 60 per cent of the cases reported to the Moral Welfare Section. The remaining cases so far reported have been divided almost equally into:—

i victims of indecent assault etc.;
ii girls exposed to moral danger;
iii girls likely to become beyond parental control;
iv absconders;
v girls not ordinarily resident in the city who have become stranded there;
vi girls referred to the department because of other behaviour difficulties.

At the beginning seven officers were appointed as Juvenile Liaison Officers. This number has since been increased to fifteen men and seven women.

Every Juvenile Liaison Officer belongs to a number of committees whose work is among the youth of the city. One of these is known as the Juvenile Delinquency Committee. It was formed by the Director of Education and is made up of members of different social organisations interested in young people. In addition, Liaison Officers are encouraged to visit youth clubs and maintain contact with both members and leaders and in fact, they are frequently invited to act as stewards at social functions. In areas where facilities for the recreation of young people are inadequate, they are instrumental in the formation of youth clubs and similar organisations to fulfil the need.

Naturally, a scheme must be judged not only by its successes but by its failures and much attention must be paid to statistics showing the failures under the Scheme. The following table records the percentage of recidivism occurring among those dealt with by Juvenile Liaison Officers. A failure is reckoned as such even though several years may elapse before a child commits a further offence, and in this respect the figures quoted are perhaps a severe test for the Scheme. Owing to the continuous nature of the Juvenile Liaison Officer's work, the totals for preceding years have been included in the calculation of the percentage of recidivism.

Year	*Total dealt with by J.L.O. Scheme*	*Recidivist*	*Percentage*
1951	631	86	13.6
1952	907	58	9.4
1953	903	65	8.5
1954	709	63	8.6
1955	805	61	8.4
1956	930	96	8.7
1957	731	75	8.9
1958	862	68	8.8

It is most encouraging that 5,906 children out of the 6,478 dealt with since the commencement of the Scheme have ceased to be delinquents.

During 1958 the number of cases of potential offenders increased to 248, the majority of these cases being brought to the notice of the police by their parents or school head teacher. When these cases are taken in conjunction with the 649 children who, during the year, were merely given words of warning and advice, it illustrated the large amount of true crime prevention work which is being done.

The Juvenile Liaison Scheme has aroused widespread interest, from all parts of the world observers have paid visits to Liverpool to study it factually in the field. It has the blessing of the Home Office, who have drawn its many advantages to the notice of all Chief Officers of Police in the United Kingdom.

* * *

One of the outstanding features of the Juvenile Liaison Scheme is the gratitude so many parents have expressed for the help given them by the police. It is rather a sad thing that even today in a big and bustling city there are so many people who need help, and could be given help if only they knew where to ask for it. Instances like these come often and repeatedly to the attention of the Juvenile Liaison Officers.

We reproduce overleaf a typical story from the case book of one of the Officers.

"Housebreaker" aged six

There was the case of the six-year-old thief who joined in the breaking and entering of houses. He was discovered after a particularly troublesome series of housebreaking offences in the south end of the city had been dealt with by detectives. The pattern of the offences was always the same: a pane of glass in the kitchen window would be broken and the window unlocked for the burglar to climb through. Inside, the target was invariably the gas or electric meter and any small articles left lying about.

This type of theft is always mean and despicable, because money stolen from meters has to be replaced by the occupants of the house, and so often they are people with little money, or old age pensioners.

The particular series of thefts was eventually tracked down to an eleven-year-old boy, who was arrested and dealt with by the Juvenile Court on the evidence of his confession of having broken into fifty houses, and on his previous record of three prosecutions for stealing and housebreaking. The boy told the police that he had been accompanied on his housebreaking offences by another youngster who shall be called Johnny—that is not his correct name.

Johnny turned out to be only six years of age, which meant that although he admitted helping the older boy on his thieving expeditions, and receiving a few coppers from the proceeds, he could not be prosecuted because he was well below the age of criminal responsibility—even if anyone had wanted to prosecute a child so young.

This obviously was a case for the Juvenile Liaison Scheme and an officer duly discovered that Johnny had a bad and sad home background. His mother had deserted his father, and the father was now living with another woman with whom he had produced two more children. The two adults and the three children, Johnny included, were living in a two-room basement flat which was poorly furnished and damp, with paper peeling from the walls, and the bedding always damp. Johnny's father was out of work and he and the woman, who was playing the role of Johnny's mother, were pathetically glad to accept the Juvenile Liaison Officer's offer of such help as he could give.

Johnny had clearly fallen into grave trouble because no one was worried about him, even when he was roaming the streets until late at night and coming under the domination of the older tougher boy. But Johnny was sorrowful enough, and his father and the woman of the home promised they would take more interest in him.

Johnny's headmistress and the local parish priest also agreed to help, and the priest extracted a promise from Johnny's father to send him to church and Sunday school regularly.

The next move by the Liaison Officer was an attempt to improve the living conditions of the family. These were so bad that there was danger to health, and the woman had become quite overwhelmed with the enormity of the task of cleaning. Once again the Liaison Officer enlisted ready aid from a voluntary organisation which had the rooms thoroughly cleaned, made damp-proof, and decorated. Apart from the practical value of this, the improvement in living conditions stimulated the interest of the father and the woman with whom he lived, and it only needed gentle persuasion from the Liaison Officer to get the man out job-hunting. He found work as a labourer in a Government establishment, and with his wages coming in regularly there was the chance to buy new furniture, to cover bare floors with linoleum and carpets, and to provide the small home comforts they had been lacking.

Johnny and the rest of the family also benefited in the shape of more and better clothes. So, within a year of coming on the scene, the Liaison Officer had the satisfaction of realising that a transformation had taken place before his eyes—a transformation in which he had played no small part. A dirty and sombre home had been brightened, neglected children were now happy and well-nourished, a father was looking the world squarely in the face, and a foster mother had been inspired to new efforts.

There was no longer any need for the Liaison Officer to keep up his visits to the house. His primary purpose—to rescue young Johnny from a potential life of crime—had long since been achieved.

"I have no worries now about Johnny, I shan't need to visit you any more," the Liaison Officer told the father.

But it is one thing for the Juvenile Liaison service to open a case. It is quite another thing to close it. The father and the woman pleaded with the Liaison Officer to continue visiting them: "You are our best friend," they said, "please call whenever you can."

Many patients suffer from a sense of frustration and resentment when they learn that they have diabetes. The health visitor helps in their readjustment

Health Visiting in a Diabetic Clinic

by ELSIE M. TATLOW, S.R.N., S.C.M., Q.N. and H.V. certs.

Health Visitor, Cheltenham

AT the end of 1956 a suggestion was made by the British Diabetic Association that the attendance of a medico-social worker at the diabetic clinics might prove a great help to both consultant and patients. An approach was made by the consultant physician in charge of the clinic, to the county medical officer of health with the request that a health visitor be appointed in this capacity. Although her duties were not actually defined, she would work under the direction of the consultant physician.

I was the health visitor appointed to attend this clinic each week, and full use of the working time there had to be organised to the best advantage.

Winning Confidence

At the clinic all new diabetic patients are interviewed by me at the request of the physician, also any of the long standing cases as and when the need for help and guidance arises. It is necessary to establish at once with a patient the feeling of confidence that one is there to help them in this or that problem. They need to be advised on their diet and taught how to adapt themselves to the amount of calories that have been worked out for their individual needs.

Often these diets are expensive, and the patients' financial circumstances are investigated so that other sources of help may be sought to lessen the burden. Sometimes clothing, convalescence or other needs arise, and I have been able to obtain help from voluntary and statutory sources for the benefit of the patients in need.

Many of the patients suffer from a deep sense of frustration and resentment when they know that they are suffering from diabetes. It is apparent that most of them appreciate being able to talk to me about it, and to learn how they can readjust themselves to living as normal a life as possible, in spite of their disability. Once they have got over the immediate shock, most of them settle down to become co-operative patients who take a tremendous interest and pride in their progress, and some even study themselves from a scientific angle.

I visit many of the patients in their homes and arrange for those who live out of this area to be visited by their local health visitors, who carry out any special instructions of the physician and send reports when necessary.

The importance of the home visits to these patients cannot be over emphasised, epecially the first one. Sometimes the hospital atmosphere and trepidation make it difficult for the patients to be at ease, but in their own homes they are able to talk and listen more freely. One comes up against many problems, not always connected with the disability, which add to the worries of the patient, but with the co-operation and help of other sources it is often possible to remove or alleviate these difficulties.

In 1957 a survey was made on the weekly cost of the special calorific diets advised. It was then seen that for many of the patients, especially those on National Assistance, it was quite impossible to provide the diet as laid down. A request was made to the National Assistance Board at Government level for an increase in allowances in special hardship cases, and we were very grateful when this request was granted.

We found also that some patients felt they could not afford the special scales for weighing their foods. The position was satisfactorily investigated and prices obtained, so that scales could be purchased at a reasonable cost, or help given through some voluntary association.

In Cheltenham a diabetic club was inaugurated recently and many diabetic patients have become members. At its meetings a variety of talks, films and demonstrations are arranged to help diabetics not only to live with their disability but also to enjoy a normal social life. Plans are being made to provide transport for members who otherwise could not attend.

Active Members Visit the Infirm

The club is hoping to help with home visiting of the sick, infirm and blind diabetics, provided that each patient intimates that he would like to be visited.

The diabetic club is able to arrange for children with diabetes to go to special holiday camps, on the recommendation of the physician in consultation with the health visitor.

We have also arranged for Christmas parcels to be sent to needy cases, and these have been much appreciated.

The cases prove to be very varied and their needs cover a wide field. We have referred cases for help to charitable societies, home helps, social workers for the blind, chiropodists, the boarding out officer (residential accommodation for children) and to churches for social contacts.

One finds that diabetics respond to the interest that is taken in them and one is able to give them a sense of hope and security, in the knowledge that, in spite of their disability, life still has a future for them.

She drives a reindeer sled over frozen lakes to reach her patients, but once there her work is that of any district nurse anywhere

Nurse in Ski-clothes

A World Health Organisation Feature

IF there were enough nurses in the world according to the World Health Organisation there would be nearly six million of them—one for every 400 members of the earth's population. Some would live lives like that of Silja Laaksonan. Silja is a public health nurse for the community of woodsmen and reindeer farmers around Isokyla, Lapland, eighty miles north of the Arctic Circle.

Perhaps Silja's life is not typical if you think of nurses in starched white uniforms answering the buzzers of restless patients in a busy hospital ward. She visits her patients dressed in ski clothes and an ear-warming Laplanders cap. Sometimes she drives a reindeer sled over the frozen lakes to reach the more remote homes of her patients.

But once she enters the door the work she does is much the same as that of any nurse anywhere in the world. She gives injections and administers medicines on the doctor's orders. She checks the weight and height and examines the tongues of school-children. She helps mothers solve the problems of feeding and caring for their newborn babies. She persuades stubborn old men to follow the doctor's orders.

Silja is 23 years old. She was trained in Helsinki and worked for a while in a hospital in Kuopio but she came north to Lapland because she wanted greater freedom and because she loves the bleak beauty of the lonely countryside and the tiny scattered villages. She does not regret her choice. In Finland nurses are well-paid, well-housed and their work is recognised and appreciated by the whole community.

At the end of the second world war, Finland was an exhausted country. Her four million people were poor, her resources depleted. In the northern regions hardly a village was left standing. But when peace finally came the Finns did not waste time looking regretfully back on the lost past. They set about to construct a more equitable and secure existence for all their people.

Three Hours' 'Daylight'

Finland has always faced a special problem in her somewhat eccentric geography. For instance in the Lapland area where Silja works, during the winter months there are only three hours of something vaguely resembling daylight. Even at high noon the sun is nothing but a pinpoint on the grey horizon.

The population of this northernmost country of Europe is scattered over a huge land area broken into isolated regions by a jagged sea coast and many lakes and forests. Well over half the people live in the countryside and many of the communities are minute—often

The biggest problem in Lapland is tuberculosis, due to bad living conditions caused by the war and to the great influx of refugees from Karelia. The situation is improving rapidly but the problem still remains. A week earlier, Silja took this patient 100 kilometres away to the capital of Lapland, Roveniemi, to have an X-ray. There are no facilities for this north of the capital. The patient should be in a sanitorium but no beds are available.

Silja chose Lapland to work in because she did not like hospital routine: also "because Lapland has hills and the summer is beautiful". The thermometer is sixteen below zero, and Silja slides round her district behind a reindeer instead of skating over hospital polished floors.

no more than three or four houses to a village.

From its beginnings in the late 19th century the Finnish health service has given thoughtful attention to the needs of the rural population.

This had two basic objectives:

(i) there should be no separation between public health services and medical services. The public health nurse and the doctor and midwife in each community should work as a team;

(ii) regardless of the comparative poverty of the small rural communes they should receive the same health services as the cities.

To achieve these ends the Government of Finland has during recent years enacted legislation to provide every commune of four thousand or less with at least one doctor, nurse and midwife.

Silja is stationed in a commune of 8,000 people and shares her nursing task with her friend Mirrku with whom she lives. They are provided by the community with a pleasant three-room apartment, furnished in the modern Finnish style. In the same building is the sauna where amid hot steam and birch boughs they take the relaxing, comforting bath so much a part of Finnish life.

The two nurses are also in charge of a small dispensary from which they supply the drugs and medications prescribed by the doctor. People may come at any time of the day or night for help or treatment.

Entertaining Themselves

The nurses' lives are full and busy but not with the common pleasures of the city. The nearest cinema is eight miles away, the nearest neighbour a twenty-minute walk.

Silja's boyfriend drives the local bus and can come to call on his nights off. For entertainment the girls are likely to read, play pingpong or paint their home-made ceramics.

There are 852 public health nurses in Finland today—an undeniable proof that a high standard of health can be achieved under the most difficult conditions.

Ever since its formation in 1948 the World Health Organisation has been co-operating with the Finnish authorities to help them make up the losses of the war and to improve their health services. The story of Silja Laaksonan, her good humour, her courage and intelligence devoted to bettering the health of her countrymen is a story that WHO hopes one day will be repeated ten million times so that all the people in the world can have the same chance of health and happiness as the lucky villagers of Isokyla.

Twice a year the rural health nurses visit the schools. Every child is checked for weight, height, and any symptoms of rickets or tuberculosis. At the same time, the mothers are asked to bring their young babies to the school to receive anti-diphtheria vaccination. The nurses work in teams for this particular job: one checks the children, the other takes the notes. The school teacher is always present.

The midwife and her pupils are well occupied, with crowded days and disturbed nights

'Other People's Babies'

by MARY E. CAMPBELL, S.R.N., S.C.M., Q.N. cert.

WHEN I began midwifery training in hospital it was with the pious hope of obtaining "another certificate." To me, at that time, the subject was a closed book—one which, in my ignorance, I thought had only to be opened, read, marked and learned, for one to become a midwife. Since then—18 years ago—I have opened, read and re-read, and am still learning. I had no knowledge of district midwifery. I never dreamed that it could be so alarming, interesting, at times amusing, un-predictable, but withal, wholly rewarding.

I live in and work from a Queen's home, with two or three (sometimes four) pupil-midwives to help train. The district is a busy one and keeps us well occupied. The pupils spend their final three months of training on the district, and despite the many disturbed nights and crowded days, few fail to enjoy this part of their training.

Theoretically, work begins at 8.30 a.m., but more often than not the telephone rings in the small hours of the night. An agitated voice (usually male) bids me to "Come at once to my wife—she's been took bad" or "Her waters have gone," and even "She's seen her colours." I must be very quick to find out her name and address before he hangs up leaving me wondering!

Arriving at the house I may find that she is in labour and either has had a pain once an hour for the last two hours, or is almost ready to have the baby. On the other hand I may find she is not in labour at all and has gone back to sleep. (This, of course, is not the rule, but it does sometimes happen—usually during the night.)

All 'my mothers' have been warned that, if labour begins or they think it has begun, they should let me know before 8.30 a.m. if possible, so that I may make them my first call. One morning, as I was about to set off, a message was brought to me: "Mrs. J. isn't well." As this could mean anything from a niggling pain to a condition requiring Caesarean section, I hastened my going.

When I reached the house I found Mrs. J. sitting calmly in front of the bedroom fire, looking very cheerful. I talked with her for a few moments before I realised that the towel on her knee was wrapped round a tiny baby. When Mr. J. had returned from telephoning, he was just in time to save the infant from landing on the floor! Knowing that the baby should be kept warm he thought the best place to do that was by the fire. The bed was only a few feet away, otherwise the third stage would have been completed by the fireside also.

In days gone by, when a prospective mother booked her midwife, it was often by accident. Perhaps, meeting her in the street the mother would mention "I'll be wanting you next month, nurse." Happily, this is rare nowadays, but in the past 18 years I admit there have been a few mothers who have failed to book at all.

I recall a certain Mrs. W. who was wont to have her baby and then send for the midwife to "come and clear up." When I first met her she had just delivered her fourth baby. It took quite a while to 'clear up' as the house was very dirty, and the rickety furniture thick with dust and grime. When I remonstrated with her, indicating the necessity for ante-natal and medical care, she pointed to her other children and said (with misplaced pride) "Never saw no doctor nor nurse before they was born. Never took them to no welfare centre neither." She knew all the answers, and interspersed them with gory adjectives.

However, my words of wisdom appeared to have reached her, for within the year she sent for me to 'come and book me.' The benefit of this was limited as she was at least twenty stones in weight, so obese that no information could be obtained by examination per abdomen. She simply informed me of the expected date of confinement, and rarely was she out by more than a day or two.

Throughout the following years she produced nine more babies on the specified dates. But she booked early in pregnancy, visited her doctor, and gradually a great improvement in her home conditions was effected also. I would like to think that this was due entirely to my persuasions, but as now her two eldest daughters are mothers, in new homes of their own, I feel she may have responded more to the competition thus provided!

Family in Attendance

Over-crowding is much less met with nowadays, but some years ago I was called to a mother who was due to go into hospital for her confinement. When the ambulance arrived to take her there, the attendant thought labour too far advanced to move her. With her husband and four children, she lived, ate and slept in one room. There was another room, just a cubby-hole containing all the things which would not fit into the living-cum-bedroom (and father, for the time being).

I had neither time nor thought to enquire where the children were. Some minutes later, as the new-born infant was yelling lustily on the bed, I felt my ankles grasped by unseen hands. Suppressing a scream, I glanced down, to see four little grinning faces appearing from under the bed! They were quickly dispatched to join father.

When the idea of relaxation and ante-natal groups was new, I went to Birmingham to take a course. I was very pleased with the results when I put into practice the knowledge thus gained. Now, my primiparas came to clinic with calm dispositions; a few had been delivered with satisfactory outcome. Then, gradually the old enemy apprehension reared its ugly head, and questions regarding abnormalities, long and painful labours, still-births, and operative intervention came thick and fast.

I was at a loss for some time to account for this. Then one day, in the middle of clinic, I entered the waiting room, to find Mrs. W. (resplendent in furs, high heels, and halo hat!) holding court. She (para 8) had that day been examined first at clinic. I did not query her presence, thinking she was waiting for someone. Later, on questioning one of her ' disciples ' I found that she was telling the gory details (with exaggerations) of her previous confinements to the poor little unsuspecting primiparas, who believed every word. She omitted to tell them, however, of her eighth confinement, when four hours after delivery I had found her very flushed of face, slurred in speech, and temperature elevated. I was perplexed until ' grandma ' came in, and staggered across the room. It didn't require the bottle in her hand nor her offer of gin to tell me they were both drunk! (Puerperium thereafter uneventful.)

Sixteen-year old Mother

One morning recently as I was about to start on my visits, a message came in " Doctor wants a midwife immediately. A baby has been born unexpectedly." I was soon at the house, and found doctor awaiting the completion of the third stage of labour. The baby, wrapped in a towel, was yelling lustily on the bed, and the mother, a girl of 16 years, looking rather dazed. The newly-made grandparents were in a state of shock; grandma in tears, and grandpa demanding that the baby should be removed from the house forthwith and adopted.

When doctor had gone to begin his belated surgery, mother had been made comfortable, and baby dressed in his first outfit of second-hand clothes which I had brought with me in anticipation, the grandparents calmed somewhat. Some semblance of order effected, the circumstances were explained to me. Mary, my patient, had finished her schooling the previous year. Her mother noticed she was getting plump but as her twin sister was also putting on weight, little was thought of it. Her father had just recently started his own business of window-cleaning and Mary helped him. That morning they had set off as usual at 8.15 a.m. in their little van, but before reaching the end of the street the ensuing conversation took place:—

Mary: " I've something to tell you."
Father: " What? "
Mary: " I'm going to have a baby."
Father: " When? "
Mary: " Now."

So, the van was reversed, and they returned home to be greeted by mother who feared there had been an accident. The conversation was repeated and she acted promptly by sending for doctor and rushing Mary upstairs to bed where twenty minutes later the baby was born.

And now, I was ordered to take the baby away. I pointed out that the baby must stay with his mother for the first six weeks of his life—this was required by law. But father would have none of it. He had seen a programme on TV a short time ago where the baby was adopted the minute after it was born.

Bringing Round the Grand-Parents

I talked, pleaded, argued for the next half hour making no headway, then I called in re-inforcements. Doctor and the health visitor came, and it took over an hour of combined persuasion to obtain father's consent to keep them both at home for the prescribed time, to make him see his duty towards the little scrap of humanity who was his first grandchild, and his bewildered daughter who was still a child herself. (The most recent information I have received concerning the much desired adoption is that the proud grandparents are trying to adopt the baby themselves!)

Feeling that, indeed, something had been accomplished that morning I set off on my delayed round of supervisory visits, blood pressure recordings, ante-natal examinations, and room visits. First I telephoned the Home to find out if any other calls had been received. One had. Mrs. H. had ' sent in ' (fourth pregnancy; twins expected; now booked for hospital confinement; three weeks premature). Wondering if anything had gone amiss, as she had sent for me instead of going straight to hospital as arranged, I hurried off.

On reaching the house I found Mrs. H. lying, grinning, on the hall floor. Doctor, kneeling beside her, was holding number one twin up by her heels, and the imminence of the number two twin was apparent. Within a few minutes, she too arrived. When we had carried mother and babies to bed (fortunately the bedroom was on the ground floor) we decided that they would remain to be nursed at home. By now it was 2 o'clock, so we (one of my pupils had arrived with the bags just after the babies were born) went home to lunch, setting out afterwards to continue the morning round.

I was about to enter the car when one of the nurses came running to inform me that " Mrs. H. was having a fit." Requesting her to notify doctor, I hurried off. Mrs. H. was comatose. Doctor and the ambulance came a few moments later, and I accompanied her to hospital, where she recovered with amazing rapidity. No signs of toxaemia had ever been found before or after delivery. The fit, therefore, was considered to be epileptic?

The rest of the day was uneventful, and after a whole night in bed I awoke refreshed, looking forward to a peaceful day, but without much hope, for these are few and far between in my life.

NURSING BOOKSHELF

Aids to Bacteriology for Nurses by E. Joan Bocock and Katharine F. Armstrong. (Balliere, Tindall and Cox. Price 10*s* 6*d*).

IN this small book there is packed a vast amount of information about a subject of great importance to both the student and the trained nurse. Without an understanding of the principles of bacteriology, many of the procedures the nurse watches, or is asked to perform in the ward and in the theatre, appear to be meaningless ritual which no one of spirit would wish to observe. But when she grasps the principles underlying the procedures, she realises that failure to observe the rules may be, literally, a fatal mistake. It is therefore advisable for her to know a good deal about bacteria and the role they play in daily life and in pathological states in man and animals.

The nurse who absorbs the contents of this book will be well equipped to deal with any bacteriological problem likely to come her way. She will find the first reading a daunting experience, as so much detail is given and considerable knowledge of chemistry and biology is assumed. Further, it is difficult for a beginner to distinguish the vital from the relatively unimportant matter. As an adjunct to lectures and practical teaching and as a book of reference, it has considerable value. **P.S.**

Midwifery, by M. Fensom, S.R.N., S.C.M., M.T.D. (Oxford University Press. Price 5*s* 6*d*.)

MISS Fensom has written this book primarily to help and guide native midwives in developing countries and for native teachers of traditional birth attendants.

The simple language used should make translation into other languages a not too difficult task.

The book is well set out and begins with an introduction in which is given the simple anatomy of the pelvis and pelvic organs. Then follow eight chapters on pregnancy, abnormal pregnancy, the physiology of labour, the care of a woman in labour, abnormal labour, the puerperium, the baby, and premature and sick babies. Each chapter is illustrated by many clear diagrams which are well labelled where necessary and add greatly to the teaching value of the manual.

There is brief mention of the value of relaxation and of the mother understanding something about labour; it is, however, a pity that contractions are sometimes referred to as pains and no suggestion made for the midwife to avoid speaking of pains in front of the patient.

Besides being of value to native midwives in developing countries, this book would be easily understood as an introduction to midwifery for nurses and those at the beginning of midwifery training. It would also be useful for members of nursing auxiliaries, W.V.S., etc., who wish to know what to do in a midwifery emergency should they be called upon in the absence of a doctor or midwife—a situation which may occur, for example, if movement in an area is restricted due to fear of atomic radiation. **R.A.B.**

Modern Surgery for Nurses, Fourth Edition, Edited by **F. Wilson Harlow, M.B., F.R.C.S. Eng.** Heinemann Medical Books Ltd. Price 30*s*.

THE fourth edition of this book for nurses has been eagerly awaited, and it is to be hoped that its readers will not be required to wait another five years for the next edition.

Much of its success as a textbook lies in the variety in the size and heaviness of the type used. This, together with its wide range of surgical subjects, makes it a very suitable reference work. Mr. Harlow and his contributors have produced an immensely worthwhile work.

To say its readers are limited to members of the nursing profession would be wrong, and Mr. Harlow himself has already expressed his pleasure that this should not be the case.

The additional illustrations are a great asset. One wonders whether a major revision of the text would be necessary in order to insert, e.g. figure 38 between pages 81–83 rather than where it is at present. The title is not displayed boldly enough and many a student is likely to pass it over, which would be a pity, or to be confused by it.

Another source for confusion is probable with regard to the complications of gastric and duodenal ulcers. This heading, clearly displayed, does not hold true in the following text. Also included are those complications which may occur after gastric surgery. A small point, perhaps, but one worthy of note because of the tendency in nurse teaching of separating the treatment and complications of medical and surgical conditions.

Special mention must be made regarding the inclusion of several valuable sections.

Chapters 27 and 28 about diagnostic tests and X-ray diagnosis, and the section on anaesthesia are subjects of which it is essential that the nurse has some understanding if she is to nurse her patients well, and to profit from her lectures and clinical studies.

In the appendix, the new chapter on the sulphonamides and the antibiotics, and that on radiotherapy (may there be some simple diagrams under radioactive isotopes next time) place this book in a class above most volumes with a similar title.

It would be unworthy to say that one section is of more value than another, or that one is written better than another Each part contributes to the whole. The whole, though heavy to hold, is one that any nurse will be the poorer for not possessing, and any medical student the less informed for not reading. **V.E.W.**

What About Nursing? by Joy Burden. Published by S.P.C.K. Price 2*s* 6*d*.

What About Nursing is intended to bring the Nursing profession in all its aspects before those who are choosing a career. In a succinct and readable form it outlines the qualities of physique and character required in the successful nurse, gives some idea of the implications of training, and points out the possible fields of post-certificate study and work. Published as it is by the Society for the Promotion of Christian Knowledge it includes a chapter on a nurse's call to the mission field and the particular contribution of the Christian faith to nursing, whether at home or abroad.

The author is inclined to sentimentalise the profession and to under-emphasise the extent of the hard work and often unglamorous duties that constitute a large part of a nurse's training and work. The book is nevertheless a useful guide to the would-be nurse; it shows that girls of many differing qualities can find their life's work in nursing, and it should certainly appeal to the adolescent.

E.M.W.

SCOTTISH NURSES RECEIVE LONG SERVICE BADGES

Photograph by courtesy of Edinburgh Evening News

Thirty-six Queen's nursing sisters attached to the Scottish branch of the Queen's Institute of District Nursing qualified for the award of the long service badge this year.

At a function held at Scottish headquarters on 30th October, attended by members of the Scottish council and friends of recipients, The Lady Mary Gilmour presented badges to twenty-two of these nurses. Our photograph shows them with Lady Mary and Miss Conner, superintendent of the Scottish branch (second from the left).

Five of the Scottish nurses decided to attend the presentation of long service badges ceremony in November at St. James's Palace.

ASSOCIATION OF DISTRICT NURSES

LANARKSHIRE

OUR annual social evening was held at the Lesser Town Hall, Hamilton, on 5th November. At this meeting we welcomed local committee members and representatives of all with whom we work, and expressed our thanks and appreciation for their co-operation.

This year our guest of honour was Miss Conner, superintendent for Scotland, who was accompanied by Miss Gilmour, superintendent of the central training home, Edinburgh. Their visit was marked by the presentation of flowers by Miss Mowat, Douglas Water and Miss Robertson, Douglas, both of whom received their long service badges in Edinburgh on October 30th.

Miss Conner thanked the nurses and said she was very happy to be amongst them, and to see that they were an active and interested section. Miss Conner remarked that this was the only active section in Scotland which she thought a great pity, but hoped the time would come when this would be rectified.

Flowers were also presented to Miss J. Ferrier, county superintendent of Lanarkshire, as a public expression of our respect and esteem, and as a token of our thanks for the work she does in helping us to organise these functions.

I. G. Goldie

NORTH-EAST METROPOLITAN

ON 19th October 1959, members were entertained to a film show, given by the North Thames Gas Board. *Smoky Chimneys* was followed by two travel films on *The Channel Islands* and *A Journey to Wales*.

This was the first time such an evening had been held, and it was gratifying to see that attendance was good. The North Thames Gas Board have promised to give a further film show, *The Gardens of Britain*, at the May meeting.

D. Heaton

Resignation of Miss Black

MISS Augusta Black has resigned from the position of education officer of the Queen's Institute, which she has held since January 1955. Prior to that, Miss Black spent five years as organising tutor to the Institute's health visitor course at Bolton.

In accepting Miss Black's resignation, members of the council expressed their thanks and warm appreciation of her services to the Institute itself and to the advancement of the education of district nurses. In particular, the council paid tribute to her pioneer work in connection with the Integrated Course of Nurse Education, which has become part of the Institute's training programme.

A District Nurse Becomes

T.V. STAR FOR A NIGHT

MY reaction was one of slight apprehension mingled with pleasure when I was asked to appear on television to describe the work of a district nurse. For the following two days my thoughts inevitably turned to the appearances, good and bad, I had seen on T.V. and I wondered how I should face up to the revealing cameras.

The time all too soon approached when I found myself going up the steps of Alexandra Palace. I announced my arrival to the receptionist and was escorted to the dressing room of Miss Nan Winton, my interviewer-to-be. Over a friendly cup of tea, Miss Winton put me at my ease. We discussed what we should say and then went in to Studio One to face the cameras for a rehearsal.

This was when my knees really started to knock, as I thought of the millions of people who might be watching; I found great difficulty in bringing out my answers, particularly as I could see myself on the screen. Fortunately it was not the real thing, and having made a quick run through we returned to the greater comfort of the dressing room together with a procession of technicians producers and cameramen, where we again ran through our interview timed by a stop watch.

In due course I was told to creep quietly to my place on the settee in the studio where Robert McDougal was already reading the six o'clock news. Strange though it may seem, my nervousness had by this time completely disappeared and I was able to enjoy my appearance.

The programme *Town and Around* started with two short films on other subjects; then came the introductory portion of film showing district nurses leaving a district home at the start of a day's work. I heard Miss Winton say "I have Miss Cunnick here in the studio to tell us something of district nursing". I was on! I found myself answering Miss Winton with ease, informing her of my work as a district nurse, the type of cases nursed, the mileage I covered and the enjoyment I derived from my work. I was prepared to continue when I heard Miss Winton say "Thank you, Miss Cunnick" and it was over—the two minutes went so quickly.

T.C.

The MANAGEMENT OF ILEOSTOMY

It remains more within the province of the nursing profession than that of the general practitioner to provide aid in the proper management of Ileostomies and Colostomies. Indeed, as far as home nursing is concerned the visiting nurse takes over and completes the educational regime to which the patient was subjected during his or her in-patient period. Questions of diet and type of appliance have probably been decided before the nurse actively enters the scene.

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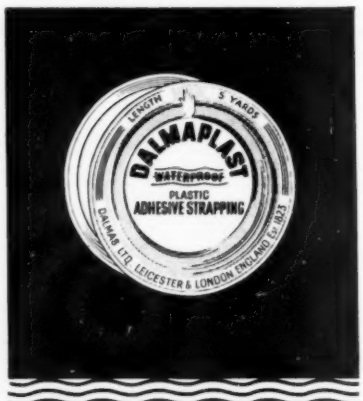

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Queen's Nurses Personnel changes 1st to 31st October, 1959

APPOINTMENTS

Superintendents

Boreham, I. J. (Mrs.), Bucks.—Asst. Supt. Dewhirst, E., Sheffield—Asst. Supt. Hall, A. D., Sheffield—Asst. Supt. McGonigle, M., Sheffield—Supt. of Home Nursing Service. Nagle, M., Sheffield—Dep. Supt. Richards, E., Oxon.—Supt. Rogerson, E. (Mrs.), Southwark—Asst. Supt. Watkins, E. M., N. London—Asst. Supt. White, M. A., S. London—Acting Asst. Supt. Tate, M., Sunderland.—Supt.

Nurses

Allen, W. M. M., Brighton. Allwork, B. A. M., Lancs. Ashworth, I., Lancs. Carter, L. B., Glos. Clohessy, M. M. (Mrs.) Brighton. Colburn, F., Lancs. Cookeman, M. A., Westmorland. Davidson, E., Lancs. Davies, P. A., Warcs. Doherty, M. H., East Ham. Harris, N. I., W. Riding. Macrae, D. (Mrs.), Cheshire. McGowan, E. T., Brighton. Morrison, U. F., Berks. Parsons, N., Essex. Potter, J. M., W. Riding. Sanders, E. E., Middx. Simpson, J. M., Lancs. Suter, J. M., Middx. Symonds, B. H., Dorset. Waite, E. M., W. Suffolk. Williams, A. C., Cornwall.

Leave of Absence

Morgan, M. A., H.V. trg. Ross, F. L., Extension of L.O.A. Swan, M. L., H.V. trg. Thistlethwaite, B., H.V. trg. Webb, E. T., H.V. trg. Whaite, A., H. V. trg.

Rejoiners

Bentley, K. I. (Mrs.), Huddersfield. Coleman, M., St. Olaves. Conroy, K., N. Riding. Culley, K. I. E., Devon. Daw, D. M. (Mrs.), Newport. Forde, M., Essex. Harwood, M. (Mrs.), Lancs. Jones, E. M. L. (Mrs.), Chester. Maynard, M. A., Devon. McCormish, E., Leeds. Powell, A. E. F. (Mrs.), W. Riding. Stirling, M. A., Devon. Wheeler, J. D., Woolwich.

Resignations

Bates, M., Bucks.—Retirement. Bevan, R. E., Bristol—H.V. trg. Billing, A., E. Sussex—Hosp. post. Bone, A. M., Croydon—Other work. Bravey, M., Reading—Domestic reasons. Buckley, M. R., York—Mid. trg. Coates, M., Camberwell—Hosp. post. Collins, C. C., York—Mid. trg. Cooper, J. E., Kent—Other work. Davies, N. E., Brighton—Emigrating to Australia. Dolan, E. F., Belfast—Marriage. Evans, D., Caerns.—Retirement. Gannon, E.M.K. Hampstead—Other work. Hett, G. M., Manchester—Retirement. Jones, L. A., Caerns.—Marriage. Jones, S. L., Caerns.—Hosp. post. Leslie, E. H., Coventry—Retirement. Levis, J., Halifax—Personal reasons. Lewis, V. M., Brighton—Mid. trg. McLaughlin, M. A., Glos.—Domestic reasons. Minnen, J., Essex—Return to Holland. Murphy, M. K., Brixton—Mid. trg. Murray, K. A., W. Sussex—Health. Park, J., Somerset—Domestic reasons. Parsons, H., Surrey—Retirement. Peggs, B., Norfolk—Hosp. post. Peterson, A. E., Belfast—Marriage. Rabbitt, M. M., Liverpool—Marriage. Redwood, C. D., Camberwell—H.V. trg. Robinson, D., Manchester—H.V. trg. Schofield, C., Halifax—Domestic reasons. Stinson, R. J., Belfast—Marriage. Smurthwaite, A., W. Riding—Other work. Timms, M. E., Stockport—Other work. Topham, M. E., Sussex—Other work. Walters, M. J., Bristol—H.V. trg.

Scottish Branch

APPOINTMENTS

Superintendents

Broadfoot, C. F., Central Training Home, Glasgow—Supt. District Nurse Tutor. Shaw, M. M., Glasgow (Dennistoun)—Asst. Supt.

Nurses

Cumming, M. S., Newport. Grassick, L., New Deer. Lawson, S. M., Clackmannans. McCormick, C. T., Campbeltown. McHardy, A., Ross-shire C.R.N. Mackie, I., Eastriggs. Maclean, D., Campbeltown. Niven, C. W., Rumford. Pickering, J., Machrihanish. Ramage, J., Dumfries-shire. Russell, J., Oban. Scullion, S., Kirkconnel. Stevens, J. C. J., Uphall Station. Stitt, V. D. M., Kirkcudbrights. C.R.N.

Transfer to England

Williams, A. C., Late of Tayvallich.

Resignations

Aitken, M. G. A., Edinburgh—Home reasons. Barclay, A., New Deer—Marriage. Chalmers, S. J., Kilmacolm—Health reasons. Clark, J. S., Ettrickbridge End—Marriage. Liston, Mrs. H., Edinburgh—Home reasons. MacCormack, Mrs. E., Dundee—Retired. McCormick, E. R., Hamilton—Marriage. MacKenzie, I., Balallan—Home reasons. MacKinnon, Mrs. C. B., Glasgow (Strathbungo)—Home reasons. Smith, J. M. S., Newport—Marriage. Turner, M. Aberdeen—Other work.

obituary

Miss Lilian Butler

WE report with regret the death on 31st October of Miss (Lellen) Lilian Butler after a short illness at her own home in Bridgwater.

Miss Butler trained at the Infirmary, St. George-in-the-East, Wapping, from 1908–1912, then took midwifery training with the West Riding Nursing Association. She was Superintendent of the Bridgwater Maternity Home and D.N.A from 1925 until her retirement in 1944.

Miss Butler was a kindly and thoughtful administrator, always ready to help in times of difficulty. She never spared herself in any way. After her retirement she continued to live with her sister near Bridgwater, where she had many friends who will greatly miss her. **M.W.**

Mrs. A. B. Ashton

WE report with regret the death on 11th October of Mrs. Adelaide Beatrice Ashton, after a short illness.

Mrs. Ashton held a post at the Springfield Mental Hospital between 1930–1935, and afterwards undertook training at the Municipal Hospital, Sunderland, from 1935–1940. She held posts as staff midwife and midwifery sister at the Royal Victoria and West Hampshire Hospital from 1940–1945. From September 1946 until the time of her death, Mrs. Ashton was district nurse midwife with the Leicestershire County Nursing Association. She will be greatly missed by her many friends and colleagues. **L.A.**

TRI-PARTITE YET ONE

IN the report of the Ministry of Health for the year 1958, the chief medical officer emphasises that "one of the natural results of the formation of the present national health service will be the inevitable development of greater co-operation between the hospital, the practitioner and the public health services. . . the illness or disability of the hospital patient does not begin at the time of his admission, nor does it necessarily end when he leaves. And since health departments are becoming increasingly concerned with domiciliary care and after-care, they share a common ground with the family physician. Tripartite as the national health service may seem to be, it is, in essence, one service. . . . Each of these three divisions is complementary to the other, and each must be envisaged in the wide setting of the service as a whole. This conception is of especial importance to the medical officer of health, for upon him will depend much of the bringing together of his own colleagues and of those in the allied services of hospital and family medicine."

The report also mentions a new low level of maternal mortality and low records achieved in the infant mortality and neonatal mortality rates, improvements brought by years of painstaking work by the staffs of local authorities.

"The mortality of infants and children has so greatly improved that we can feel that we are in reach of the goal of giving humanity a healthier life though not necessarily a much longer one. That may perhaps be effected later."

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Displayed Setting: 17s. 6d. per single column inch. Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.)

APPOINTMENTS

NORFOLK COUNTY COUNCIL

Applications are invited for vacancies in the undermentioned areas:—

District Nurse/Midwife/Health Visitor (preferably with Queen's and H.V. Certificate or willing to train)

Gt. Melton. Unfurnished house.

Fincham. Unfurnished house later.

Harleston. Unfurnished bungalow.

Hockham, nr. Thetford. Unfurnished house.

Long Stratton, South Norfolk. Second nurse, living separately. Furnished accommodation.

Neatishead. Unfurnished house.

Tacolneston. Unfurnished house.

District Nurse/Midwife (S.R.N., S.C.M., and preferably with Queen's Certificate)

Fakenham. Increase of staff. One of three nurses living separately. Unfurnished house.

Wymondham. Part-time relief duties.

Dereham. Part-time relief duties.

Thetford. Part-time relief duties (temporary).

Full-time Midwife (S.R.N., S.C.M., and preferably with Queen's Certificate)

King's Lynn. Two vacancies. Unfurnished house and unfurnished flat.

Full-time Midwife or District Nurse/Midwife willing to do combined duties

Watton. Furnished accommodation—house being built.

Facilities available for Health Visitor and Queen's Nurse training with a view to generalised duties.

Staff needed for relief duties—holidays or longer periods.

Whitley Council salaries and conditions of service.

Successful applicants can use their own cars (loans available for purchase) or cars can be provided. Consideration will also be given to supplying furniture if required.

Application forms from County Medical Officer, 29 Thorpe Road, Norwich, Norfolk.
NOR. OIT.

MIDDLESEX COUNTY COUNCIL

Domiciliary Midwife (wholetime) reqd. in Area 4.(Finchley and Hendon). Must be S.C.M. and preferably S.R.N. N.M.C. Salary, plus London Weighting, if applicable. Provision for uniform. Small furnished house available—suitable for married couple. Should be able to drive a car. Car allowance. Established, prescribed conditions. Full particulars and two referees to Area Medical Officer, Town Hall, Hendon, N.W.4 by 10th January, 1960. (Quote B.472D.N.J.)

SOMERSET COUNTY COUNCIL

(Midwifery and Nursing Services)

Taunton—S.R.N., S.C.M. preferably with district training. Resident in comfortable nurses' home or non-resident.

Yeovil—Two S.R.N., S.C.M.s required, preferably with district training. Comfortable nurses' home, resident or non-resident (one house available).

Peasedown St. John (near Bath)—Two Queen's Nurse/Midwives/Health Visitors required. Two cars provided. Small fully furnished house.

Batheaston (adjoining Bath)—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district in group of four nurses. Car provided. Lodgings, house to be built.

Chilcompton—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district. Car provided. Lodgings, house to be built.

Bleadon (adjoining Weston-s-Mare)—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district. Car provided. Accommodation available.

High Littleton—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district in group of nurses. Car provided. Small furnished flat available.

Wookey (near Wells)—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Furnished bungalow available. Motorist.

Financial help given with driving tuition.

For further particulars apply to: County Medical Officer of Health, County Hall, Taunton.

YORKSHIRE—WEST RIDING COUNTY COUNCIL

Appointment of Senior Relief Midwives and Home Nurse/Midwives

Applications are invited from suitably qualified nurses and midwives for the following new appointments on the headquarter's staff.

Three **relief midwives** based on Doncaster, Barnsley and Rotherham.

Five **relief district nurse/midwives** based on Shipley, Harrogate, Wakefield, Pontefract and Brighouse.

Salary and conditions of service will be in accordance with the Whitley Council recommendations, plus an additional payment of £50 0 0 per annum and expenses when away from headquarters.

Applicants should be able to drive a car.

Applications forms, together with details, relating to the above vacancies may be obtained from the County Medical Officer, County Hall, Wakefield, Yorkshire.

COUNTY BOROUGH OF SOUTHEND-ON-SEA

Home Nursing Service–Male District Nurse

Applications are invited for appointment as District Nurse—(Male). Must be S.R.N. District training an advantage.

Salary and conditions of service in accordance with the Award of the Nurses and Midwives Council of the Whitley Councils for the Health Services.

Housing accommodation may be made available if required, and a car allowance is payable.

Forms of application can be obtained from the Medical Officer of Health, Municipal Health Centre, Warrior Square, Southend-on-Sea, to whom they should be returned within three weeks of the appearance of this advertisement.

ARCHIBALD GLEN, Town Clerk

BRECONSHIRE COUNTY COUNCIL

(In membership with the Queen's Institute of District Nursing)

Public Health Department

Applications are invited for the following posts:—

1. **District Nurse/Midwife/Health Visitors/School Nurses** for the following areas:
   - (a) **Brecon Rural (Merthyr Cynog, etc.)**
   - (b) **Beulah area**
   - (c) **Llanwrtyd Wells area**

Applicants must be S.R.N. and S.C.M. and hold the Health Visitor's certificate.

A car is essential for each appointment. (A scheme for the assisted purchase of a car is available up to 100% loan, or a car can be provided by the Authority.) Whitley salary and conditions of service.

Scholarships are offered for training as Queen's Nurse and/or Health Visitor.

The District Councils do all they can to see that the nurses in their areas are provided with houses, and in Brecon it is possible that the house already allocated to a nurse will become vacant shortly.

Forms of application and further particulars can be obtained from the County Medical Officer, Health Department, Watton Offices, Brecon, and should be returned within two weeks of the appearance of this advertisement.

Other Advertisements on p. 196

LANCASHIRE COUNTY COUNCIL
Home Nursing Service
Trainee Nursing Administrators

Applications are invited from nurses with the qualifications S.R.N., S.C.M., H.V., with District Training for appointment to the Headquarter's Relief Staff for employment in the first instance on generalised duties.

Special consideration will be given to nurses who are interested in taking **further training** with a view to obtaining **Nursing Administrative posts.**

Whitley Council Salary Scales. Car drivers essential. Appointments superannuable and subject to medical examination. Applications to County Medical Officer of Health, Serial 1976, East Cliff County Offices, Preston, who has details of other vacancies.

DORSET COUNTY COUNCIL
(Member of Queen's Institute)
DISTRICT NURSE-MIDWIVES

Applications are invited from **district nurse-midwives** for single area post in North Dorset comprising Mappowder and surrounding rural area.

Unfurnished house available. Whitley salary and service conditions. Motorist essential. Car provided or allowance piad.

Applications form from the Clerk, County Hall, Dorchester to be returned by 24th December, 1959.

WEST SUFFOLK COUNTY COUNCIL

Hadleigh. District Nurse Midwife required in January to share the work in a small market town with one other nurse. Motoring area.

Newmarket. District Nurse Midwife required for town. Motorist or Cyclist. Unfurnished flat provided.

Conditions of service as recommended by Whitley Council for Health Services.

Apply County Medical Officer, Westgate House, Bury St. Edmunds.

ISLE OF MAN
HEALTH SERVICES BOARD
Douglas, Isle of Man

District Nurse/Midwife required for April 1960. S.R.N., S.C.M. willing to take district training considered. Car provided. Salary and conditions of service in accordance with Whitley Council.

Closing date for applications 31st December 1959. Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

HEREFORDSHIRE COUNTY COUNCIL

Applications are invited for the following appointments:—

Hereford City. District Nurse/Midwife for combined duties. Accommodation available. Cyclist or motorist—car provided.

Madley and Madley/Pontrilas. Two District Nurse/Midwives for combined duties in adjoining rural districts near Hereford. Good house, furnished or unfurnished. Motorists—cars provided or allowances for own cars. Would suit two friends; normally off duty together.

Ross-on-Wye. District Nurse Midwife/Health Visitor for generalised duties in mainly rural area. Motorist—car provided or allowance for own car. Future plans for house or flat.

Bromyard. Health Visitor for full time Health Visitor/School Nurse duties in Market town and surrounding rural area. Motorist—car provided or allowance for own car. Own living ararngements.

Application forms and terms of appointment may be obtained from the County Medical Officer, 35 Bridge St., Hereford.

QUEEN'S NURSES' BENEVOLENT FUND
Change of Address

As from 1st January 1960, Miss Ivett's address will be:

St. Anthony's,
Marine Hill,
Clevedon,
Somerset.


trict Nursing